Wyoming Insurance Department

Review Requirement Checklist

Small Group Health

Contact:
Wyoming Insurance Department
(307) 777-7401
(307) 777-2446(fax)

Updated 05/2015

Wyoming Insurance Department	Statutes	http://legisweb.state.wy.us
Wyoming Insurance Department	Rules and Regulations	http://soswy.state.wy.us
Wyoming Insurance Department	Memoranda/Dept. Position	
REVIEW REQUIREMENTS	**REFERENCE**	**COMMENTS**
General Requirements	W.S. §26-15-110	Filing Requirements
Transmittal Letter	Wyoming Uniform Filing Procedure	All filings shall:
		Contain the company’s name, address, NAIC number and company phone number.
		Be sent in duplicate.
		Have a self-addressed, postage paid envelope.
		Have a “SUBJECT” line briefly describing the filing type.
		Contain an itemized listing of each policy form and endorsement, including form number.
		Contain the name of the individual responsible for the preparation of the filing.
		Contain a Certification of Compliance signed by an officer of the company, attorney or actuary.

Actuarial Memorandum	Reg., Ch. 49, § 7	Shall certify rates are reasonable in relation to the benefits provided and that the insurer is in compliance with W.S. §26-19-301, *et seq.* in the format set forth in APPENDIX A.
Forms		No filing fee for rate or form filings.
Policy Contents and Identification	W.S. §26-15-113	The policy shall specify: -the names of the parties to the contract; -the subject of the insurance; -the risks insured against; -the time when the insurance takes effect and the period during which the insurance continues; -the premium; -the conditions pertaining to the insurance; and -benefits payable.
Renewal or Extension	W.S. §26-15-121	The policy shall be renewable at the option of the insured except for: -nonpayment of premium; -fraud or misrepresentation by the insured; or -the insurer elects to nonrenew.
Assignability	W.S. §26-15-122	The policy is assignable or not assignable as provided by its terms.
Proceeds Exempt From Claims of Creditors	W.S. §26-15-131	Except as otherwise provided by the policy or contract, the proceeds are exempt from claims of creditors.
Coverage Availability	W.S. §26-19-306	A small employer insurer is required to file its basic and standard plans for prior approval in the format prescribed by the Commissioner.
Preexisting Conditions		The insurer shall use the HIPAA 6-12 preexisting condition language with portability credit for creditable coverage continuous to within ninety (90) days of the enrollment date.
Late Enrollees		Late enrollees may be excluded from coverage for the greater of eighteen (18) months or an eighteen (18) months preexisting condition exclusion, provided that if both a coverage exclusion and a preexisting condition exclusion are applicable, the combined period shall not exceed (18) months.

Minimum Contribution and Participation Requirements		The insurer shall apply these provisions uniformly among all small employer groups with the same number of eligible employees. Participation requirements may vary only by group size. In applying minimum participation requirements, the insurer shall not consider employees or dependents that are otherwise covered by a public or employment based health benefit plan in determining whether the applicable participation percentage is met.
Requirement to Insure All Employees		The insurer shall offer coverage to all eligible employees and dependents. Save for preexisting conditions and late enrollees, the insurer shall not modify a health benefit plan by rider, endorsement, restrict or exclude coverage or benefits for specified diseases, medical conditions or services otherwise covered by the plan.
HMO Affiliation Period		The HMO may provide for an affiliation period only if: - no preexisting condition exclusion is imposed; - the affiliation period is applied uniformly without regard to any health statue related factors; and -the affiliation period does not exceed two (2) months or three (3) months in the case of a late enrollee.
Exceptions to Coverage		The insurer shall not be required to offer coverage in the case of the following: - where the employer is not physically located in the insurer's geographic service area; - when the employees does not work or reside within the geographic service area; - within an area where the insurer demonstrates a capacity limitation; - if accepting new applications would place the insurer in a financially impaired condition.
Required Provisions	W.S. §26-19-107	
Entire Contract		The policy, endorsement and application, if any, of the policyholder and person insured constitutes the entire contract.
Notice of Claim		Written notice of claim shall be given to the insurer within twenty (20) days or as soon as reasonably possible.

Claim Forms		The insurer shall furnish claim forms within fifteen (15) days of notice.
Proof of Loss		Written proof of loss shall be furnished to the insurer within ninety (90) days of the loss or as soon as reasonably possible.
Claims Payment		Other than benefits for loss of time, benefits are payable not more than forty-five (45) days after receipt of proof of loss and supporting documentation.
Examination and Autopsy		The insurer, at its own expense, may examine the insured as often as reasonable during pendency of a claim and make an autopsy, if not prohibited by law.
Legal Action		No action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss and no action shall be brought after three (3) years.
Grace Period		The policyholder is entitled to a thirty one (31) day grace period for the payment of premium due except the first. The policy shall continue in force during the grace period unless the policyholder gives the insurer advance written notice of discontinuance.
Incontestability		Except for nonpayment of premium, the validity of the policy shall not be contested after it has been in force for two (2) years form the date of issue.
Misstatement of Age		If premiums or benefits vary by age, a provision shall specify an equitable adjustment of premiums, benefits or both if the age of the covered person is misstated and the manner of doing so.

Nondiscrimination		No policy shall treat the following as a preexisting condition: - pregnancy existing on the effective date of coverage; -genetic information absent a diagnosis of a condition related to the genetic information. No policy shall establish rules for eligibility, including continued eligibility based upon any of the following health status related factors: - health status; - medical condition, including both physical and mental illness; - claims experience; - receipt of health care; - medical history; - genetic information; - evidence of insurability, including conditions arising out of acts of domestic violence, and; - disability.
Payment of Benefits		Benefits are payable to the insured or to his designated beneficiary (ies) or to his estate. If the insured is a minor or otherwise not competent to give a valid release, the benefits may be made payable to his parent, guardian or other person actually supporting him. At the insurer's option and unless the insured requests otherwise in writing no later than at filing of proof of loss, benefits may be paid directly to the hospital or person rendering the service(s).
Cancer Screening		The policy shall provide benefits for breast, cervical, colorectal and prostate cancer screens without application of a deductible with a $250 per year benefit. Policies with a deductible of $1000 or higher are exempt.
Group Replacement	W.S. §26-19-201	The policy shall provide for continuance of coverage for all participants when a succeeding carrier's contract replaces a prior plan's benefits as prescribed in this section.

Non-COBRA State Continuation	W.S. §26-19-113	The policy shall provide that employees, and/or their covered dependents and association members, whose coverage under the group (2 to 19 employees) would otherwise terminate because of termination of employment or membership or eligibility for coverage, are entitled to continue their insurance under the group policy, still in effect, for themselves, their dependents or both, subject to all of the group policy's terms and conditions and as prescribed in this section.
Non-custodial Children	W.S. §26-15-135	The policy shall have a provision that it may not refuse to provide medical coverage for a dependent child for the sole reason that the child is not living in the home of the parent applying for the policy.
All Licensed Health Professionals	W.S. §26-22-201	The policy will provide that reimbursement for covered services shall not be denied if the services are rendered to the insured by a person licensed under the laws of Wyoming to treat the illness or disability or perform the health services covered by the contract or policy.
Public Institutions	W.S. §26-22-201	The policy may not exclude payment as to tax supported institution if charges are made for services.
Adopted Children	W.S. §26-22-101	The policy must provide coverage for an adopted child from the earlier of the date of the petition for adoption or entry of the child in the adoptive home.
Newborns	W.S. §26-22-101	The policy must provide coverage on family contracts for a newborn for injury or sickness including congenital defects and birth abnormalities.
Diabetes Coverage	W.S. §26-22-201	The policy shall provide coverage for outpatient self-management and training.
Mentally Physically Handicapped	W.S. §26-20-401	The policy must provide coverage beyond the limiting age for physically or mentally handicapped children as long as the handicap exists.
Conversion Privilege	W.S. §26-22-201	The policy shall require a conversion offering to an insured that has been covered for at least three (3) months immediately prior to termination.
Inherited Enzymatic Disorder Coverage	W.S. 26-40-401 et seq	Effective 07/01/2013, coverage must be included for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for inherited enzymatic disorders.

Prescription Eye Drop Refill Coverage	W.S. 26-20-501 et seq	Effective 07/01/2015, coverage for prescription eye drop refills must be dispensed as follows: (i) if a renewal is requested by the insured at least twenty-three (23) days for a thirty (30) day supply, or at least forty-five (45) days for a sixty (60) day supply, or at least sixty-eight (68) days for a ninety (90) day supply; and, (ii) one additional bottle of prescription eye drops if requested by the insured or the practitioner at the time the original prescription is filled, and the original prescription states that one (1) additional bottle is needed by the insured for use in a day care center or school. The benefits provided shall be subject to the same annual deductibles, copayments or coinsurance established for all other covered benefits within a given policy.
Oral Chemotherapy Parity with Injectable and Intravenous	W.S. 26-20-601 et seq	Effective July 01, 2015, coverage for oral chemotherapy must be covered in parity with injectable and intravenous therapy regardless of the formulation or benefit category determination by the policy or contract issuer; and, (b) No issuer of a health insurance policy or contract shall comply with this requirement by increasing the copayment, deductible or coinsurance amount required for covered injected or intravenous chemotherapy or by reclassifying benefits with respect to cancer treatment medications.